FOR NY RESIDENTS ONLY

Underwritten by: RAUSHOME.COM

Group TRICARE Standard/Extra Supplement Plan ASSOCIATION & SOCIETY INSURANCE CORPORATION

Transamerica Financial Life Insurance Company, Harrison, NY, a Transamerica company POLICY HOLDER: AMERICAN MILITARY INSURANCE TRUST ORGANIZATION: RETIRED ASSOCIATION FOR THE UNIFORMED SERVICES

Check the appropriate block:	\square New enrollment	\square Add dependent(s)	☐ Change coverage	RAUS Mem	ber #:
Member's Information					
			(PLEASE LEAVE B	LANK) REF. NO	
(□ Mr. □ Mrs. □ Ms.) LAST	FIRST	INITIAL	Date of Birth	://_	
STREET ADDRESS			Rank and Se	rvice:	
CITY			Check One:	\square TRR	□ Widow(er) □ Active Duty
STATE	ZIP CODI	E			☐ Former Spouse
() TELEPHONE NO: HOME	() OFFICE		Military Retir	ement Date:	
Dependent Information					
Name of each dependent for v	whom coverage is de	esired:			
Spouse:			\square Male \square Female	Date of Birth: _	/
Child:			\square Male \square Female	Date of Birth: _	/
Child:			☐ Male ☐ Female	Date of Birth: _	//
Child:			☐ Male ☐ Female		/
Child:			☐ Male ☐ Female		/
(Complete additional sheet if necessary.)				_	
Retired Member ☐ High Option II Retiree Pla Spouse of Active Duty Me ☐ Active Duty Family II Plan	n	e of Retired Member Option II Retiree Plan Child of Active Duty we Duty Family II Plan	□ Higł	Child of Retired n Option II Retiree	
I hereby enroll myself and/or my dependence of the Program. I understand that I must be a following receipt of this enrollment form I understand that any injury or sickness within the 6 months immediately precent of the property of the pr	member of RAUS to be eling and premium. ss, whether diagnosed or useding their effective date	igible for coverage and that undiagnosed, for which any	my coverage will become person proposed for cov	e effective on the first rerage has received m	day of the month edical treatment or care
NY Residents: Any person who knowingly and with inten misleading, information concerning any fact material ther violation.					
Member's Signature (X)				Date	
Spouse's Signature (X)				Date	
		(IF ENROLLING)			
Signature of Agent (X)			_ Agent No	General A	gency No
PRINT: NAME OF AGENT			PHONE I	NO.	
AGENT'S ADDRESS					

BUDGET YOUR PAYMENTS WITH

CHECKOMATIC...

THE DIRECT MONTHLY PAYMENT PLAN

Your TRICARE Supplement Plan premiums can be deducted directly from your checking account every month.... with no worries about missing a payment and losing your valuable insurance protection. Simply complete the Request and Authorization form at the right. Enclose a blank check (marked VOID) to be kept on file. All future premiums will be deducted from your checking account automatically on the first business day of each month. Completed form and void check must be received by the 15th of the month prior to the month of deduction.

CHECKOMATIC REQUEST FORM AND BANK CHECK AUTHORIZATION (Please Print)

NAME OF BANK DEPOSITOR AS SHOWN ON BANK RECORDS		
NAME OF INSURANCE APPLICANT (If not Bank Depositor)		MEMBER ID
CHECKING ACCOUNT NO.	NAME OF BANK AND BRANCH	
ABA (BANK ROUTING NUMBER)		

As a convenience to me, I request and authorize Association & Society Insurance Corporation or another Transamerica Financial Life Insurance Company (NY residents only) or administrator/representative to initiate electronic debit entries each month and charge them to my checking account as indicated above. Authority to charge such debits to my account shall become effective as of the date this authorization is signed and shall remain in effect until revoked by me in writing.

I agree that the bank's rights, with respect to each debit, shall be the same as if it were drawn and signed by me. I further agree that, should any debit be dishonored, whether with or without cause, the bank shall be under no liability whatsoever, even though such dishonor results in the termination of insurance.

Γ	SIGNATURE OF	DATE
	DEPOSITOR X	

INDEMNIFICATION AGREEMENT

TO: The bank named in the authorization

In consideration of your compliance with the Depositor's Checkomatic Request and Authorization, the Association & Society Insurance Corp. (the "Plan Administrator") agrees that:

- 1. It will indemnify and hold you harmless from any liability to any persons arising out of payments by you, in accordance with the terms of this Request and Authorization, of any draft or debt advice drawn by means of commercial paper on the specified checking account by the Plan Administrator and payable to the order of the Plan.
- 2. It will refund to you any amount erroneously paid by you to the Plan on any such draft or other debit advice if claim for the amount of such erroneous payment is made by you within twelve months of the date of the instrument on which erroneous payment was made.
- 3. It will defend, at its own cost and expense, any action which may be brought by any persons because of your action taken in accordance with the terms of this Request and Authorization or arising in any manner by reason of your participation in the preauthorized payment plan requiring your acceptance of the Request and Authorization.

094-9/10 ASSOCIATIO

ASSOCIATION & SOCIETY INSURANCE CORPORATION

REMEMBER, SEND A VOIDED CHECK ALONG WITH THIS FORM AND YOUR PREMIUM PAYMENT

Monthly Premium Rates—Retirees

Age	High Option II Plan	Active Duty Plan	
Under 40	\$ 26.33		
40 - 44	\$ 28.33		
45 - 49	\$ 31.67		
50 - 54	\$ 40.00		
55 - 59	\$ 50.33		
60 - 64	\$ 55.67		
Each Child of Retiree	\$ 21.00		
Spouse of Active Duty Member	Not Available	\$ 8	
Each Child of Active Duty Member	Not Available	\$ 7	

Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the insured person and increase as you enter each new age category.

RAUSHOME.COM



RAUS MEMBERSHIP APPLICATION

The Retired Association for the Uniformed Services, Inc. 326 Main Street, Franklin, Tennessee 37064-2614 800-321-RAUS Fax 615-790-2210

OFFICE USE ONLY	
Member #	
Certificate #	

М	ember Name:	Last Name	Fir	st Name	Ini	tial		Social	Security #		/ Dat	te of Birth
Sp	ouse Name:	Last Name		st Name	Ini	tial			Security #	<u>/</u>	<u>/</u>	te of Birth
Ad	dress:	Street			Cir				State		ZIF	
Mi	litary Data:	Branch Rank	Service #		/ / ary Entry l	Date	/ Disch	/ arge Date	<u> </u>	Email	l Address	
Ch	eck One:	[] Retired []	Widow(er)	[] TRR	[] Ac	tive Duty		Military	Retiremen	t Date: _		
onl und ben	I hereby request membership in RAUS to take advantage of the member- only association benefits. I have included the initial membership dues and understand that, except for Life Membership, continued membership and benefit enjoyment requires renewal of my membership upon expiration of the initial period. DUES RATES Amount [] 1 year membership \$15.00 [] 3 year membership \$37.00 [] 5 year membership \$60.00 [] Life memberships are based on age. (See below)											
I	Date	Pho	ne:		Sign	ed:						
	Life Membership AGE RANGE 40 or less 41 to 45 46 to 50 51 to 55 56 to 60 61 to 65 66 to 70 70 and up LIFE DUES \$325 \$300 \$275 \$250 \$225 \$200 \$175 \$100											
THE RAUS ASSOCIATION RAUS is a non-political military association organized in 1970 to secure quality benefits for its members at rates only available to groups. Qualified retired and active members of the United States armed forces and related departments may join RAUS by making application and paying the membership dues. Association benefits are available to all members, their spouses and eligible dependents. The various association benefits are designed for the needs of the general membership and therefore will change from time to time. The association objective is to always provide membership benefits as follows: newsletter; insurance products; discount buying and travel services; credit cards; other products and services as deemed feasible.												
		l Active duty mil e. Membership a		nnel may	join the				ilitary br	anches	and mi	litary
 military members military spouse members dependents 					5.	widows widowe former	ers	se				
	M	AIR FORCE ARMY COSTAL & GEODETIC SU MARINES NAVY NATIONAL GUARI			C SURV SERVICE							

Write two checks--one check for your premium payable to SelmanCo, and one for your dues payable to RAUS. Mail membership application and enrollment forms with your checks for dues and premium to:

RAUS 326 Main Street Franklin, TN 37064-2614